# Referral Form – Domestic Abuse Service

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| CASE INTAKE FORM – Office only | | | |
| Client ID / ref no. | Case worker | Risk level | Repeat? |
|  |  |  | Y / N |

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| Intake date |  | Client aware of referral? |
| **Referrer details**  Name/Address/Phone/email |  | Y / N  If no, please advise that the client must choose to engage with SignHealth’s service |
| Involvement with client? |  |

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| Client details | Name/AKA | | | | | | DOB & age | | | Gender: | | |
|  | | | | | |  | | |  | | |
| Address | | Safe to write? | | Alternative address | | | | | | | Safe to write? | |
|  | | Y/N | |  | | | | | | | Y / N | |
| Email | |  | | | | | | Safe to email: Yes  No | | | | |
| Mobile | |  | | | | | | Safe to text: Yes  No | | | | |
| Code word/safe time to contact | |  | | | | | | | | | | |
| Ethnicity | |  | | | | | | | | | | |
| Religion | | Christian  Sikh  Buddhist  Other  Hindu  None  Jewish  Don’t know/not sure  Muslim  Would rather not state | | | | | | | | | | |
| Language(s) spoken | |  | | | | | | Interpreter required? Y  N | | | | |
| Can the client read and write in English? | |  | | | | | | | | | | |
| Sexual orientation | |  | | | | | | | | | | |
| Marital Status | | Single  Married  Civil Partnership  Divorced  Separated  Widow  Prefer not to say | | | | | | | | | | |
| Immigration status and any concerns | | British Citizen  Asylum Seekers  Refugee  Spousal Visa  EEA National  Other | | | | | | | | | | |
| Access to Public Funds? | | Yes  No | | | | | | | | | | |
| What is their housing situation? | | Mortgage, private rent, council, sole or joint tenancy? | | | | | | | | | | |
| What is their level of deafness? | | Deaf BSL | Deaf SSE | | | Deaf Oral | | | Deaf but can’t sign | | | Hard of Hearing |
| Any other disability? | |  | | | | | | | | | | |
| Types of abuse | | Physical | Sexual | | | Verbal | | | Financial | | | Emotional |
| Describe relationship and living arrangements  (eg on/off; client lives at mum’s/(ex) partner stays over occasionally etc) | |  | | | | | | | | | | |
| Drug / alcohol / mental health issues / diagnosis treatment | |  | | | | | | | | | | |
| Describe employment (eg occupation / unemployed / in training or education / financial status / benefits). Include addresses & contacts) | |  | | | | | | | | | | |
| Is the client experiencing domestic abuse now? | | Y/N  If no, does the client need emotional support or want to join a survivor group? | | | | | | | | | | |
| Does the referrer assess that the client could pose a risk to SignHealth staff? Y □ N □ | | | | | | | | | | | | |
| If yes, consider steps that need to be taken/can support safety be offered? | | | | | | | | | | | | |
| Any agencies involved with the client now? | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Does the client feel they are safe now? | | | | | Y  N | | | | | | | |
| Do they feel the children are safe? | | | | | Y  N | | | | | | | |
| Does they have somewhere to stay if they need to leave?  e.g family, friends | | | | | Y  N | | | | | | | |
| Are they aware of access to safe refuge? | | | | | Y  N | | | | | | | |

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| **Partner / ex-partner / family member details** | Name/AKA | | DOB & age | Gender |
|  | |  | M / F |
| Address | | Drug / alcohol / mental health issues / diagnosis / treatment | | |
| No fixed addresses.  Living with client – Y  / N | |  | | |
| Has this person had involvement with police?  Are there a restraining order? | | |
| Ethnicity |  |  | | |
| Religion |  |
| Languages spoken |  |
| Physical description of perpetrator: | | |
| Deaf or Hearing? | Deaf:  Hearing: |
| Height : Build :  Hair colour:  Distinguishing features : | | |
| Immigration issues and any concerns |  |

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| **Children’s details** | Gender | DOB / age | Deaf /  Hearing | Is (ex-)partner parent of child / unborn baby? (if not, state who parent is) | | Does (ex) partner have PR? | | School |
| Name | M / F |  | D / H |  | | Y / N | |  |
| Name | M / F |  | D / H |  | | Y / N | |  |
| Name | M / F |  | D / H |  | | Y / N | |  |
| Is the client pregnant? | Y  N | | | | Due date | |  | |
| Living arrangements and address (if different to client details above) |  | | | | | | | |
| CYPS involvement | Y  N |  | | | | | | |
| Describe involvement (Flag significant concerns regarding children. Any issues with child contact?) |  | | | | | | | |

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| SIGNIFICANT CONCERNS FLAG (eg staff safety issues / serial or repeat perpetrator /suitable times to call client / HBV / suicide or self-harm concerns / MARAC case) |
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| Reason for referral / details of incident prompting referral / history of relationship, including police call outs / A & E attendances / injuries / children witnessing |
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| What does the client hope to receive from SignHealth services? |
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| **Office only** | | |
| **Checklist** | SafeLives Dash risk checklist completed | Y / N |
| Referred to MARAC | Y / N |
| ISSP in place | Y / N |
| Confidentiality and information sharing agreement consented to by client | | Y / N |
| Service explanation provided | | Y / N |
| Monitoring and evaluation of data consented to by client | | Y / N |
| Is there a conflict of interest in this case? | | Y / N  If yes, discuss with your manager |
| **Other** |  | |

PLEASE NOTE COMPLETED REFERRAL TO BE SENT TO THE FOLLOWING ADDRESS [da@signhealth.org.uk](mailto:deafhope@signhealth.org.uk)